UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

SOUTH CENTRAL INDIANA SCHOOL TRUST,	)	
Plaintiff,	)	
v.	)	CASE NO. 1:06-cv-1053-RLY-WTL
VIRGINIA POYNER,	)	
Defendant.	)	

APPENDIX TO PLAINTIFF'S MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

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Tab

Tab 1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
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SOUTH CENTRAL INDIANA SCHOOL TRUST,	)	
Plaintiff,	)	
v.	)	CASE NO. 1:06-cv-1053-RLY-WTL
VIRGINIA POYNER,	)	
Defendant.	)	

DECLARATION OF JULIE A. BURTON

Julie Burton, being duly sworn upon her oath, deposes and states as follows:

1. I am over the age of twenty-one (21), and I have personal knowledge of the matters set forth herein.

2. I am currently and at all times relevant was the Deputy Treasurer of the South Central Indiana School Trust (the "Trust").

3. In my capacity as Deputy Treasurer of the Trust, I am aware of all matters relating to the composition of the Trust.

4. My review of the records of the Trust reveals that at the time of Ms. Poyner's accident in March 2005:

(a) The Trust provided benefits to 1,618 employees;

(b) One hundred thirty-nine (139) or roughly 8.59% of the employees provided benefits by the Trust were non-governmental employees; and

(c) The non-governmental employees participating in the Trust included individuals working for Franklin College, a private, not-for-profit institution, the Indiana Association of School Principals, an Indiana not-for-profit

corporation, and the Indiana State School Music Association, also an Indiana not-for-profit Corporation.

5. In addition, I am familiar with the Employee Summary Plan Description for the South Central Indiana School Trust. Exhibit A, hereto, is a true and accurate copy of the Employee Summary Plan Description.

I AFFIRM UNDER THE PENALTIES FOR PERJURY THAT THE FOREGOING REPRESENTATIONS ARE TRUE.

Dated: July 3, 2007

Julie A. Burton
JULIE A. BURTON

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Exhibit A

MEDICAL and DENTAL
PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

SOUTH CENTRAL INDIANA SCHOOL TRUST

Restated April 1, 2005

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INTRODUCTION

Your coverage is issued by a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement.

Not withstanding any other provisions in this document, the Plan is intended to comply with the MEWA Final Rule promulgated by the Indiana Department of Insurance(760 IAC 1-68-1 *et seq.*). The Plan provides benefits in accordance with the minimum requirements set forth in the MEWA Final Rule as interpreted in the sole discretion of the Plan.

This document is a description of South Central Indiana School Trust Employee Summary Plan Description (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Participating Employers fully intend to maintain this Plan indefinitely. However, they reserve the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Plan Exclusions. Shows what charges are **not** covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Defined Terms. Defines those Plan terms that have a specific meaning.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

SCHEDULE OF BENEFITS

Verification of Eligibility (800) 550-2427

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Hospitalizations
Skilled Nursing Facility stays

Please see the Cost Management section in this booklet for details.

PPO name:	Sagamore Health Network, Inc.
Address:	SAG1681 (HCFA11C/UB50) P.O. Box 6051 Indianapolis, IN 46206-6051
Telephone:	(800) 364-3469
E-mail:	www.sagamorehn.com

PPO name:	Encore
Address:	P.O. Box 80612 Indianapolis, IN 46240
Telephone:	(800) 446-5844
E-mail:	www.encoreconnect.com

The Plan also has a National Network which can be utilized for services received outside of the Sagamore or Encore areas.

PPO name:	Beech Street
Address:	P.O. Box 853925 Richardson, TX 75085-3925
Telephone:	(800) 877-1444
E-mail:	www.beechstreet.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the country or out of the PPO service area and has a Medical Emergency requiring immediate care. Non-emergencies require a review.

If a Covered Person receives Physician or anesthesia services by a non-Network Provider at an in-Network facility.

If a Covered Person is referred to a non-Network Provider by an in-Network Provider.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

Note: Each Employee may choose a PPO during enrollment or special enrollment periods. Early Retirees may change PPO's when relocating back to an in-Network area.

HEALTH BONUS PROGRAM

A health bonus program may be offered in connection with the Plan. Please consult with the Claims Administrator for more information.

PPO PLAN

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	$2,000,000	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Note: In and Out of Network deductibles are separate.		
Low Deductible		
Per Covered Person	$300	$900
Per Family Unit	$600	$1,800
High Deductible		
Per Covered Person	$700	$2,100
Per Family Unit	$1,400	$4,200
Very High Deductible		
Per Covered Person	$1,500	$4,500
Per Family Unit	$3,000	$9,000
The Calendar Year deductible is waived for the following <u>In Network</u> Covered Charges: - Routine physical and well baby care (up to the current maximum on the plan) - Routine pap smear - Routine mammogram - Routine colorectal screenings - Routine PSA testing - Home Health Care (limited to the current maximum number of visits on the plan) - Diagnostic lab charges incurred with LabOne (not affiliated with in or out of network) - Eligible Organ Transplant charges incurred at a Specialized Transplant Network		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (includes deductible)		
Note: In and Out of Network out of pockets are separate.		
Low		
Per Covered Person	$1,300	$3,900
Per Family Unit	$2,600	$7,800
High		
Per Covered Person	$1,700	$5,100
Per Family Unit	$3,400	$10,200
Very High		
Per Covered Person	$2,500	$7,500
Per Family Unit	$5,000	$15,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Copayments Non-covered charges		

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospital Services		
Room and Board	80% after deductible the semiprivate room rate	60% after deductible the semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	60% after deductible Hospital's ICU Charge
Outpatient Surgery and All Related Charges on same day	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible
Allergy serum and injections	80% after deductible	60% after deductible
Diagnostic X-ray and Lab	80% after deductible	60% after deductible
LabOne Services	100% no deductible	100% no deductible
Home Health Care	100% no deductible	60% after deductible
	100 visits Calendar Year maximum combined	
Private Duty Nursing (Inpatient when beyond the scope of facility nurse)	80% after deductible	60% after deductible
Hospice Care	80% after deductible	60% after deductible
Ambulance Service	80% after deductible	60% after deductible
Jaw Joint/TMJ	80% after deductible	60% after deductible
	$2,000 Lifetime maximum combined	
Wig After Chemotherapy	80% after deductible	60% after deductible
	$500 Lifetime maximum combined	
Occupational Therapy	80% after deductible	60% after deductible
Speech Therapy	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Orthotics	80% after deductible	60% after deductible
Spinal Manipulation Chiropractic	80% after deductible	60% after deductible
	40 visits up to $1,000 Calendar Year maximum combined	
Mental Disorders/Substance Abuse		
Inpatient	80% after deductible	60% after deductible
	30 days Calendar Year maximum combined	
Partial Hospitalization	60 days Calendar Year maximum combined	
Outpatient	80% after deductible	60% after deductible
	50 visits Calendar Year maximum combined	
Note: There is a 60 day Lifetime maximum for Substance Abuse.		
Routine Well Baby	100%	
	Immunizations administered prior to age two, and as required thereafter by Indiana State Board of Health. Check-ups prior to age one (one), limited to four (4) visits.	
	$350 Calendar Year maximum combined	
Routine Physical Physical exam and corresponding tests	100%	100%
	$350 Calendar Year maximum combined	

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Routine Pap Smear One per Calendar Year Not included with Routine Physical	100%	100%
Routine Mammogram Not included with Routine Physical	100%	100%
Age 35-39 ..... one baseline mammogram Age 40 and over ..... one each year		
Routine PSA Testing	100%	100%
One (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age or is younger than fifty (50) years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.		
Routine Colorectal Screenings	100%	100%
At least 50 years of age, or less than 50 years of age if high risk. Frequency of tests is limited to those set by the American Cancer Society.		
Routine Well Newborn Care	80% after deductible	60% after deductible
Organ Transplants		
Eligible Transplant Procedure	**Specialized Transplant Network** 100% of covered charges	**Non Specialized Network** 90% after $2,500 deductible up to $50,000 maximum; then 100% (Deductible and coinsurance do not apply to major medical deductible and coinsurance maximums)
Donor Coverage	80% after deductible $10,000 Donor Lifetime maximum	60% after deductible $10,000 Donor Lifetime maximum
Pregnancy	80% after deductible	60% after deductible

OUT-OF-AREA PLAN

	OUT-OF-AREA	
MAXIMUM LIFETIME BENEFIT AMOUNT	$2,000,000	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$300	
Per Family Unit	$600	
The Calendar Year deductible is waived for the following Covered Charges: - Routine physical and well baby care (up to the current maximum on the plan) - Routine pap smear - Routine mammogram - Routine colorectal screenings - Routine PSA testing - Home Health Care (limited to the current maximum number of visits on the plan) - Diagnostic lab charges incurred with LabOne (not affiliated with in or out of network) - Eligible Organ Transplant charges incurred at a Specialized Transplant Network		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (includes deductible)		
Per Covered Person	$1,300	
Per Family Unit	$2,600	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Copayments Non-covered charges		
COVERED SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Hospital Services		
Room and Board	80% after deductible the semiprivate room rate	
Intensive Care Unit	80% after deductible Hospital's ICU Charge	
Outpatient Surgery and All Related Charges on same day	80%, after deductible	
Skilled Nursing Facility	80% after deductible	
Physician Services		
Inpatient visits	80% after deductible	
Office visits	80% after deductible	
Surgery	80% after deductible	
Allergy testing	80% after deductible	
Allergy serum and injections	80% after deductible	
Diagnostic X-ray and Lab	80% after deductible	
LabOne Services	100%, no deductible	
Home Health Care	100%, no deductible	

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Private Duty Nursing (Inpatient when beyond the scope of facility nurse)	80% after deductible	
Hospice Care	80% after deductible	
Ambulance Service	80% after deductible	
Jaw Joint/TMJ	80% after deductible $2,000 Lifetime maximum	
Wig After Chemotherapy	80% after deductible $500 Lifetime maximum	
Occupational Therapy	80% after deductible	
Speech Therapy	80% after deductible	
Physical Therapy	80% after deductible	
Durable Medical Equipment	80% after deductible	
Prosthetics	80% after deductible	
Orthotics	80% after deductible	
Spinal Manipulation Chiropractic	80% after deductible 40 visits up to $1,000 Calendar Year maximum	
Mental Disorders/Substance Abuse		
Inpatient	80% after deductible 30 days Calendar Year maximum	
Partial Hospitalization	60 days Calendar Year maximum combined	
Outpatient	80% after deductible 50 visits Calendar Year maximum	
Note: There is a 60 day Lifetime maximum for Substance Abuse.		
Routine Well Baby	100% $350 Calendar Year maximum	
	Immunizations administered prior to age two, and as required thereafter by Indiana State Board of Health. Check-ups prior to age one (one), limited to four (4) visits.	
Routine Physical Physical exam and corresponding tests	100% $350 Calendar Year maximum	
Routine Pap Smear One per Calendar Year Not included with Routine Physical	100%	
Routine Mammogram Not included with Routine Physical	100%	
Age 35-39..... one baseline mammogram Age 40 and over ..... one each year		
Routine PSA Testing Screenings	100%	
One (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age or is younger than fifty (50) years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.		
Routine Colorectal Screenings	100%	
At least 50 years of age, or less than 50 years of age if high risk. Frequency of tests is limited to those set by the American Cancer Society.		
Routine Well Newborn Care	80% after deductible	

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Organ Transplants **Eligible Transplant Procedure**	**Specialized Transplant Network** 100%	**Non Specialized Network** 90% after $2,500 deductible up to $50,000 maximum; then 100% (Deductible and coinsurance do not apply to major medical deductible and coinsurance maximums)
Donor Coverage	80% after deductible $10,000 Donor Lifetime maximum	
Pregnancy	80% after deductible	

PRESCRIPTION DRUG BENEFIT

Pharmacy:	
Retail Option:	
Retail Calendar Year Deductible - $100 per person	
Generic drugs	$15 copayment
Formulary Brand Name drugs	$30 copayment
*** Non-Formulary Brand Name drugs**	$45 copayment
Mail Order Option:	
Generic drugs	$10 copayment
Formulary Brand Name drugs	$40 copayment
*** Non-Formulary Brand Name drugs**	$60 copayment

- **Any Brand Name Drugs with Generic available will have the applicable co pay plus the difference in cost between the brand name drug and the generic substitute unless the prescription indicates dispense as written.**

Drugs dispensed by a non network pharmacy are not covered.

Medically necessary **Prescription Drugs** (injectibles/infusions) costing over $1,000 and dispensed in a physician's office, will be paid under Major Medical, subject to deductible and co-insurance. The American Health Care Partnership nurse must be contacted prior to receiving these drugs to arrange pricing through your Pharmacy Benefit Manager. If this is not done, the benefit will be the maximum of what is charged for the same drug by the Pharmacy Benefit Manager.

DENTAL BENEFITS

Calendar Year Deductible:	
Per Covered Person	$50
Per Family Unit	$100
The deductible applies to these Classes of Service: Basic Major Orthodontia	
Dental Percentage Payable:	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontia Services	50%
Maximum Benefit Amount:	
Per person per Calendar Year For Preventive, Basic and Major Services (combined)	$1,000
For Orthodontia Per person, per lifetime	$1,000

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Employee coverage. The definition of eligibility is determined by the Participating Employers. See the Participating Employers for details.

In connection with a Participating Employers:

For all schools except those listed below:

(1) Any elected or appointed official or certified Employee is eligible for coverage on the first (1st) day of the month following date of hire.

(2) Any non-certified Employee is eligible for coverage on the first (1st) day of the month following sixty (60) days of employment.

For Franklin College and Richland-Bean Blossom, all Employees are eligible the first (1st) day of the month following date of hire.

For Southwestern Consolidated School District of Shelby County:

(1) All certified Employees are eligible on the first (1st) of the month following date of hire.

(2) All classified (non-certified) Employees are eligible on the first (1st) of the month following (60) sixty days of employment.

Failure of the Employee to enroll within thirty (31) days following the eligibility date will cause the Employee to be a Late Enrollee at the time of future employment, unless the Employee qualifies for Special Enrollment.

If the Employee declines to enroll at the time of initial eligibility due to other coverage of the Employee or Dependent, the Employee must state in writing that the reason for declination is due to other coverage. Failure to make the written statement will void the right to Special Enrollment at a future date.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Retiree and Spouse Coverage. If an Employee retires after becoming eligible for Medicare coverage as provided by 42 U.S.C. 1395, et seq,; the Employee is not entitled to continue coverage under this Plan past their retirement date.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS (cont'd)

The Spouse of a Employee who retires after becoming eligible for Medicare coverage provided by 42 USC 1395 *et seq*. may continue participating in this Plan, subject to the same conditions and limitations noted in the Early Retiree and Dependent's Coverage section below. The Spouse of the Retiree must be covered as a Dependent on the Employee's medical insurance plan through the Trust for twelve (12) months prior the Employee's retirement in order to be eligible to continue and must elect to continue coverage as a Covered Person at the time of the Employee's retirement. If the Spouse does not elect to continue this coverage at the time of the Employee's retirement, it cannot be obtained at a future date. The Spouse may be required to pay the full cost of such coverage. The period of time during which a Spouse is entitled to this continuation of coverage shall not otherwise extend the COBRA continuation period that would apply.

Early Retiree and Dependents Coverage. Upon retirement, Comprehensive Major Medical coverage for an Early Retiree and his covered Dependents may be continued. An Early Retiree may elect to continue coverage for himself at the time of retirement or must notify his or her Participating Employer within 90 days of the retirement that he wishes to be allowed to consider enrollment for himself at a future date. However, a Dependent of an Early Retiree must be enrolled in the Plan at the time of the Early Retiree's retirement and must elect continuation coverage at the time of the early Retiree's retirement. If coverage is not continued for the Dependent at the time of retirement, it cannot be obtained at a future date. The Early Retiree and/or dependent Spouse may be required to pay the full cost of such coverage. The period of time during which a Spouse in entitled to this continuation of coverage shall not otherwise extend the COBRA continuation period that would apply.

Survivorship Coverage. In the event of the death of a covered Active Employee, Comprehensive Major Medical Benefits for his covered Dependents will be continued, at no cost to the Dependents, for up to twelve (12) months, but not beyond the earliest of the following:

(1) for each individual Dependent, the date on which he ceases to be a Dependent as defined in this Plan;

(2) for all Dependents, the date the surviving Spouse remarries;

(3) for all Dependents, the date the Plan terminates;

(4) for each individual Dependent, the date they become covered by another group plan or Medicare. (A Dependent is not eligible for this extension of benefits if he is covered by another group plan or Medicare at the time of the Employee's death).

If the surviving wife gives birth to a child of the Employee after the death of the Employee, the dependent child shall become covered on the date he would have become covered if the Employee had continued to be covered under the Plan, subject to the terms listed above (if applicable).

Dependents may be eligible for COBRA coverage at the end of coverage under this provision of the Plan. However, the period of time during which a Dependent is entitled to this survivorship coverage shall not otherwise extend the COBRA continuation of coverage period that would apply due to loss of coverage.

FUNDING

Cost of the Plan. The Participating Employers may share the cost of Employee and Dependent coverage under this Plan with the covered Employees. If so, the enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS (cont'd)

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage.

A Covered Person will be provided a certificate of Creditable Coverage if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date, or after a 3 month period ending after the enrollment date during which the participant receives no medical advice, diagnosis, care or treatment. This time may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within three months ending on an individual's "enrollment date" in the plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate patrol deduction authorization if applicable.

Enrollment Requirements for Newborn Children.

If at the time of birth, the covered employee already has dependent coverage, the newborn will also be covered from birth. Administratively, the covered employee will need to enroll the eligible newborn however; the newborn will continue to have coverage even after the 31 days without being considered a late enrollee.

If at the time of birth the covered employee did not have dependent coverage, the newborn will automatically be enrolled in the Plan for 31 days, but must be enrolled prior to the 31st day. The covered employee must enroll the newborn and select family coverage and make appropriate contributions in order for the newborn to continue as a covered dependent. If the child is not enrolled within 31 days of birth, the enrollment will be considered a late enrollment.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis (based on the above), there will be no payment from the Plan and the covered parent will be responsible for all costs.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS (cont'd)

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, the individual is a considered a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins the first of the month after enrollment.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Participating Employers contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or his or her Participating Employer's contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS (cont'd)

(2) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the date of the marriage;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee and Dependent Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

1. New Employees shall be covered on the day they become eligible, provided they are Actively at Work on that date, unless such absence is due to health related reasons, otherwise on the first (1st) day they are Actively at Work thereafter.

2. New Dependents shall be covered simultaneously with Employees covering them as Dependents or on the date acquired by the Employee.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS (cont'd)

TERMINATION OF COVERAGE

Employee Termination of Coverage. Subject to Employee's COBRA rights, the coverage of any Employee covered under this Plan shall terminate on the earliest of the following dates:

(1) the date of termination of the Plan;

(2) through the end of the month for which premiums have been paid when the Employee is no longer eligible except in the event of death of an Employee. In the event of death, the date of death applies;

(3) the date he becomes a full-time member of the armed forces of any country;

(4) the latest of the following:

(a) the date through which the last contribution was made in the event of non-payment of the required contribution toward the cost of coverage;

(b) the end of the month for which the Employee was last paid or in the event of an earlier payment of the Employee's final pay, the end of the month for which the Employee was scheduled to receive the final pay; or

(c) if termination occurs after the Employee has completed the term of employment required for the year, the coverage will remain in force until the term of employment would begin for that Participating Employer's succeeding year.

Unpaid Leave of Absence. An Employee who is either placed on, or is considered to be on unpaid status by the Employee's Participating Employer, may continue coverage under the Plan past the time that the Participating Employer ceases its contribution to the Plan for the Employee on unpaid leave, by the Employee paying the entire cost of continued coverage. Coverage may be continued under these circumstances for a maximum time period as established by the Employee's Participating Employer.

Extension of Benefits due to Total Disability. If a Covered Person is Totally Disabled on the date his coverage would otherwise terminate, Comprehensive Major Medical coverage for the disabling condition may be continued if the Covered Person pays the required contribution toward the cost of such extended coverage. A Covered Person is not eligible for this extension of benefits if he is covered by another group plan or Medicare at the time of termination of coverage.

For the purpose of this provision, the term "totally disabled" shall mean that the Covered Person:

(1) if an Employee is unable to engage in any occupation for wage or profit and is unable to perform the substantial duties of any occupation or business for which he is qualified due to Illness or Injury;

(2) if a Dependent is unable, due to Illness or Injury, to engage in the normal activities of an individual of like age and sex who is in good health.

Coverage under this provision of the Plan shall terminate upon the first to occur:

(1) the date total disability ends;

(2) the end of the twelve (12) months from the date coverage would have otherwise terminated;

(3) the date the Covered Person becomes covered by another group plan or Medicare; or

(4) the end of the period for which the last contribution was made in the event of failure to pay the required contribution towards the cost of the coverage.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS (cont'd)

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Participating Employers will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Dependent Termination of Coverage. Subject to a Dependent's COBRA rights, the Dependent coverage with respect to each Dependent, shall cease on the last day of the month that such individual ceases to be a Dependent as defined in this Plan, and the Dependent coverage with respect to all Dependents of an Employee, shall cease on the date the Employee's coverage terminates.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS (cont'd)

In the event that an Employee's or Dependent's coverage under this Plan should terminate, all benefits shall also terminate with the exception that covered expenses incurred prior to termination will be paid as provided under the terms of the Plan.

Termination of Coverage for Early Retiree, Spouse and Dependents. Continuing coverage under this provision of the Plan shall terminate for a Covered Person at the end of the month in which the first of the following occur:

For an **Early Retiree**, the earlier of:

(1) the date he becomes eligible for Medicare coverage as provided by 42 U.S.C. 1395; or

(2) the date one of the events listed below under For Early Retirees and Dependents of Retirees or Early Retirees occurs.

For a **Spouse**, who has elected at the time of the Retiree's or Early Retiree's retirement to participate in this Plan, the earlier of:

(1) the date of the Spouse's remarriage; or

(2) the date the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395, et seq.; or

(3) the date the Spouse becomes eligible for another employer-sponsored group health insurance plan; however, if the Retiree or Early Retiree has died after coverage was continued after retirement in accordance with this provision, this item (3) will not terminate coverage eligibility for the surviving Spouse until two (2) years after the date of the Retiree or Early Retiree's death; or

(4) the date the Spouse ceases to meet the definition of Dependent; or

(5) the date when one of the events listed below under For Early Retirees and Dependents or Retirees or Early Retirees occurs.

For a **Dependent**, not including the Spouse, the earlier of:

(1) the date he ceases to fit the Plan definition of Dependent; or

(2) the date the Early Retiree coverage terminates; or

(3) the date he becomes eligible for another employer-sponsored group health insurance plan; or
the date when one of the events listed below under For Early Retirees and Dependents of Retirees or

Early Retirees occurs.

For **Early Retirees and Dependents of Retirees or Early Retirees**, the earlier of:

(1) the end of the period for which the last contribution was made toward the cost of coverage in the event of non-payment of the requested contribution; or

(2) the date the Participating Employer from which the Retiree or Early Retiree has retired either withdraws completely from this Plan or withdraws the class of Employees in which the Early Retiree was included at the time of retirement; or